

# Seizure Integrated Care Pathway

## Paediatric Assessment Unit Admission Form



LUTON &  
DUNSTABLE  
UNIVERSITY  
HOSPITAL

### Addressograph

Hospital Number:

Name:

DOB: ...../...../.....

Sex: M/ F

Address:

Post code:

### GP details:

Age of the child: .....yrs.....months

Source of referral: GP A&E

Other (specify):

### Person accompanying the child

Name

Relationship

Contact number

### Person with parental responsibility

Name

Date of birth

Relationship

Contact  
number

Religion

Ethnic group

School/Nursery

Health Visitor

Contact Number

Social Worker

Contact number

CPP in place Yes/ No

Does the child/parent speak English? **Yes / No**

If No what language do they speak? .....

Interpreter required: **Yes / No**

Arrival Time:

Date:

PAU Consultant:

Completed by( print Name):

Ward attending admitting consultant:

Signature:

Designation:

Problems/Complaints:

Duration

1. ....

2. ....

3. ....

What are the carer's main concerns?

.....  
.....

Has the child been in contact with any infectious diseases?

Yes / No

**Does the patient meet the sepsis criteria?**

(febrile, tachypnoea, tachycardia)

If yes, follow sepsis pathway

(inform registrar/consultant immediately)

**PEWS on admission:**

Category on Admission

**RED**

**AMBER**

**GREEN**

If appropriate, have you completed an All About Me form? (only if not completed in last 6 months, unless significant changes)

Yes / No

# Nursing assessment

Date: .../.../.....

Time:.....

<b>Airway</b>	
<b>Breathing</b>	
Respiratory rate	
O2 Saturations	
Work of breathing	
<b>Circulation</b>	
Heart rate	
CRT	
BP	
<b>Disability</b> (commence hourly neurological observations)	
AVPU / GCS	
<b>Exposure</b>	
Temperature	
Pain(0-10/FLACC)	
Rash	
Bruises	

<b>Anthropometry</b>	
<b>Weight</b>	<b>Kg</b> (centile.....)
<b>Height</b>	<b>Mt</b> (centile.....)
<b>BMI</b>	(centile.....)
<b>Head circumference</b>	<b>cm</b> (centile.....)

<b>Intake</b>	
Food	
Fluids	
<b>Output</b>	
Urine	
Stool	
Other	

**Safeguarding concerns: Yes Not known**

Checked by Name:.....

Sign:.....

CPP in place Yes No

Previous safeguarding concerns: Yes No

If yes, name of registrar/consultant informed:

Dr.....Grade.....

Action required: Yes / No.

If yes what action:

## Allergies:

Medications:

Food:

Others:

## Medication recently administered:

1.....time:.....

2.....time:.....

## Regular medications:

**Preferred preparation:** Tablet Liquid

**Route of administration:** Oral NG Gastrostomy

Nursing notes:.....  
 .....  
 .....  
 .....  
 .....  
 .....

**Staff member completing form:**

Name:

Designation:

Signature:

Date:

Time:

If any red/amber flag, escalate to Senior Clinician

**Patient Details (affix label):**

NHS No:

Hospital No:

Name:

DOB:

- 1)** Tick
- Is the child feverish or looking sick? ☐
- Has PEWS triggered  $\geq 3$ ? ☐
- Is parent/carer very worried? ☐

**Low risk of sepsis.**  
If concerned, discuss with senior clinician ST4 or above, reassess within 2-4 hours.  
Use standard protocol, review if patient deteriorates.

NO

**2) Could this be an infection?** Tick

- Yes, but source unclear at present ☐
- Pneumonia/likely chest source ☐
- Meningitis/Encephalitis ☐
- Urinary tract infection ☐
- Abdominal pain, drawing legs up or distension ☐
- Acquired bacteraemia (eg group B strep) ☐
- Device related infection ☐
- Other infection (please specify): ☐

NO

**4) Any AMBER flag criteria?** Tick

- Abnormal response to social cues/not smiling ☐
- Reduced activity, very sleepy or abnormal behaviour ☐
- Nasal flaring or increased work of breathing ☐
- Capillary refill  $>3$  seconds ☐
- Reduced urine output ( $<1\text{mL/kg/hr}$  if catheterised) ☐
- Pale or flushed ☐
- Leg pain or cold extremities ☐
- Immunocompromised ☐
- Trauma/surgery/procedure in last 6 weeks ☐
- \*\* Moderate tachypnoea (see below) ☐
- \*\* Moderate tachycardia (see below) ☐

\*\*If in isolation, discuss with senior clinician ST4 or above within 15 minutes

YES

**3) Is one RED flag present?** Tick

- Unresponsive to social cues/difficult to arouse ☐
- Health professional very worried ☐
- Grunting respiration or apnoeic episodes ☐
- Severe bradycardia ( $<60\text{ bpm}$ ) ☐
- No wet nappies/not passed urine in 18 hours ☐
- Non-blanching rash or mottled/ashen/cyanotic ☐
- Temperature  $<36\text{ C}$  ☐
- If under 3 months, temperature  $>38\text{ C}$  ☐
- Indwelling plastic device (central line/VP shunt) ☐
- \*\* Severe tachypnoea (see below) ☐
- \*\* Severe tachycardia (see below) ☐
- \*\* SpO<sub>2</sub> $<92\%$ /new need for oxygen (see below) ☐

NO

\*\* If in isolation, discuss with senior clinician ST4 or above within 15 minutes

YES

**If 1 amber criteria present:**

- CBG to check lactate

If 2 or more amber criteria present or lactate  $>2$ , complete ALL of the following:

- Send bloods (FBC, U&E, CRP, cultures)
- Urine dipstick and send for MCS
- Immediate call to senior (ED/Paeds ST4 or above)
- Time clinician attended

Is lactate  $>4\text{mmol/L}$

Y ☐ N ☐

NO

**RED FLAG SEPSIS**  
START SEPSIS 6 NOW (See reverse)

Reassess hourly. Clinician to make antibiotic decision within 3 hours  
Discharge at discretion of senior doctor with appropriate safety netting

	Severe tachypnoea	Moderate tachypnoea	Severe tachycardia	Moderate tachycardia
$<1$ year	$>60$	50-59	$>160$	150-159
1-2 years	$>50$	40-49	$>150$	140-149
3-4 years	$>40$	35-39	$>140$	130-139
5 years	$>29$	27-28	$>130$	120-129
6-7 years	$>27$	24-26	$>120$	110-119
8-11 years	$>25$	22-24	$>115$	105-114
$>12$ years	$>25$	20-24	$>105$	100-104

**Action complete (ALL within 1 hour)**

Time Zero

Name of consultant/senior doctor informed

Initials

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**1) GIVE HIGH FLOW OXYGEN**

- Unless contraindicated

Time completed

Initials

Reason not done/variance

**2) OBTAIN IV/IO ACCESS, TAKE BLOODS**

- Blood cultures, blood glucose, lactate, FBC, U&E's, CRP, blood gas.
- Urine dipstick and send for MCS.
- Lumbar puncture (if clinically indicated).

Time completed

Initials

Reason not done/variance

**3) GIVE IV/IO ANTIBIOTICS (IM if appropriate)**

- If older than 3 months – Ceftriaxone.
- If less than 3 months – Cefotaxime and Amoxicillin.
- In Penicillin allergy – consider Vancomycin.
- If encephalopathic - consider Aciclovir and Clarithromycin.
- If indwelling plastic device, follow antibiotic guideline.

Time completed

Initials

Reason not done/variance

**4) CONSIDER IV/IO FLUIDS**

- If hypotensive/lactate >4mmol/L, give 20ml/kg 0.9% sodium chloride within 10 minutes.
- Reassess and repeat if required.
- If second fluid bolus required, inform senior clinician ST4 or above.
- \* Beware fluid overload! Examine for hepatomegaly, creps, gallop.
- \* DKA, cardiac condition.

Time completed

Initials

Reason not done/variance

**5) ENSURE SENIOR DOCTOR ATTENDS**

- Involve senior doctor (ED/Paediatric ST4 or above).
- Monitor strict input/output.
- Inform Paeds Consultant (via switch).

Time completed

Initials

Reason not done/variance

**6) CONSIDER INOTROPES/VASOPRESSORS**

- If normal physiology is not restored after 40mL/kg: consider Adrenaline (may be given via peripheral cannula /IO).
- Inform CATS /Anaesthetics.

Time completed

Initials

Reason not done

**Antibiotics reviewed at 48 hours**

Date and time of R/V: .....

Blood culture results available: Y ☐ N ☐

Antibiotics stopped at 48hrs Y ☐ N ☐

**Medical assessment:**

**Presenting symptoms:**

Name Dr.....

Designation:.....

Time seen:.....Date:...../...../.....

**Please write a detailed description**  
**Remember mnemonic ACOPEA. If**  
**there are more than 1 type of**  
**seizure, describe each separately.**

**Antecedent events** in the past 24  
hours  
•Any triggers/ warning/ aura (e.g .  
missed AED doses, unwell, late  
night)

**Context**  
•What was child doing?  
•Time and duration of seizure:

**Onset):** what was the first thing  
observed at the onset:  
Was there any change in skin  
colour?

**Progression: What happened next**  
•Did the child fall to the ground? If  
so, how?  
•Was the child responsive?  
•What happened to the eyes?  
•Were there any movements of the  
face / body? (e.g. shaking, jerking,  
eyelid flickering)  
•If yes, state what / where?  
•Did it start one side or  
symmetrically?  
•Change in breathing pattern  
•Duration of this phase ?

**End**  
•Was the child stiff / floppy?  
•Any change in skin colour?  
•Incontinence?

**Aftermath/Recovery/Post ictal state**  
What did the observer of seizure do  
Did they give any medication to stop  
seizure? if yes, at what point?

Who are you taking history from? .....  
Is this the witness of the event? .....

**A**

**C**

**O**

**P**

**E**

**A**

**Seizure history**

**Is child a known epileptic? YES / NO**

**Is there a family history of epilepsy or febrile seizures? .....**

**Is there history of neonatal seizures? .....**

**Presenting illness:**

**Past Medical History:**

## **Medical assessment cont**

**Birth History**

Gestation:..... Birth weight:.....

**Neonatal period****Feeding history**

Immunisation up to date yes / no

If no, which imms. not given?

**Development**

Gross motor

Fine motor

Social

Speech

Vision

Hearing

**School Progress****Family History**

Married / Partners / Separated / Divorced

Are Parents consanguineous ? Yes / No

**Family Tree**

	Yes	No
Drug & Alcohol Misuse		
Sexually active		
Pregnant		

**Medication on admission**

Name of medicine	Dose	Frequency	Route	Indication
Names of seizure Medication	Dose	Frequency	Route	mg/kg/day
Name of Rescue Medication	Dose	Emergency Care plan Y/ N	Route PR/ Buccal	



## Examination

**General Condition:**

**Communicative / Non-communicative**

**Dysmorphic Features**      **Yes/ No**

If yes specify:

**Posture:**    **Normal / abnormal**

Anaemia                      Jaundice                      Cyanosis

Lymphadenopathy

**Respiratory :**

**Cardiovascular:**

**Abdominal:**

**Central Nervous System: CN 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12**  
**Normal / Not normal** , if not normal give details

**Pupils:**

**Cerebellar Examination:**            **normal / abnormal**  
 Give details:

PNS	Right Upper	Right Lower	Left Upper	Left Lower
Tone				
Power				
Sensation Light touch / pain				
proprioception				

**Skin: incl. any neurocutaneous stigmata**

**ENT:**

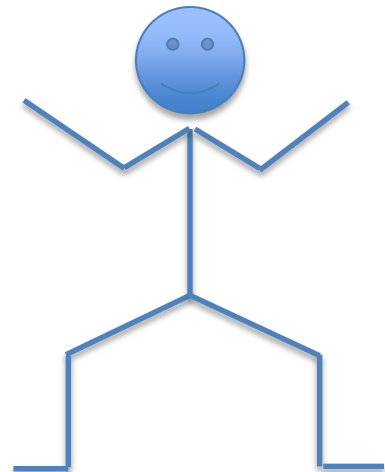
Time:.....:.....Date:.....

Temperature	
Heart Rate	
Respiratory Rate	
O2 Saturation	
CRT	
BP	
Please reassess neurological status	A V P U  GCS
Head Circ (OFC) Centile	

**Reflexes:**

Right

Left



**Musculoskeletal + Spine**

**Eyes:**

## Diagnosis

(see page 11 for guidance)

## Investigations Planned

Bloods: FBC ☐ U & E's ☐ CRP ☐ Cultures ☐ Other

CBG ☐

ECG ☐

EEG ☐

MRI ☐

CT ☐

Other

## Management Plan

Frequency of neurological observations

Management plan explained and agreed with family? **Yes / No**

Dr's name:

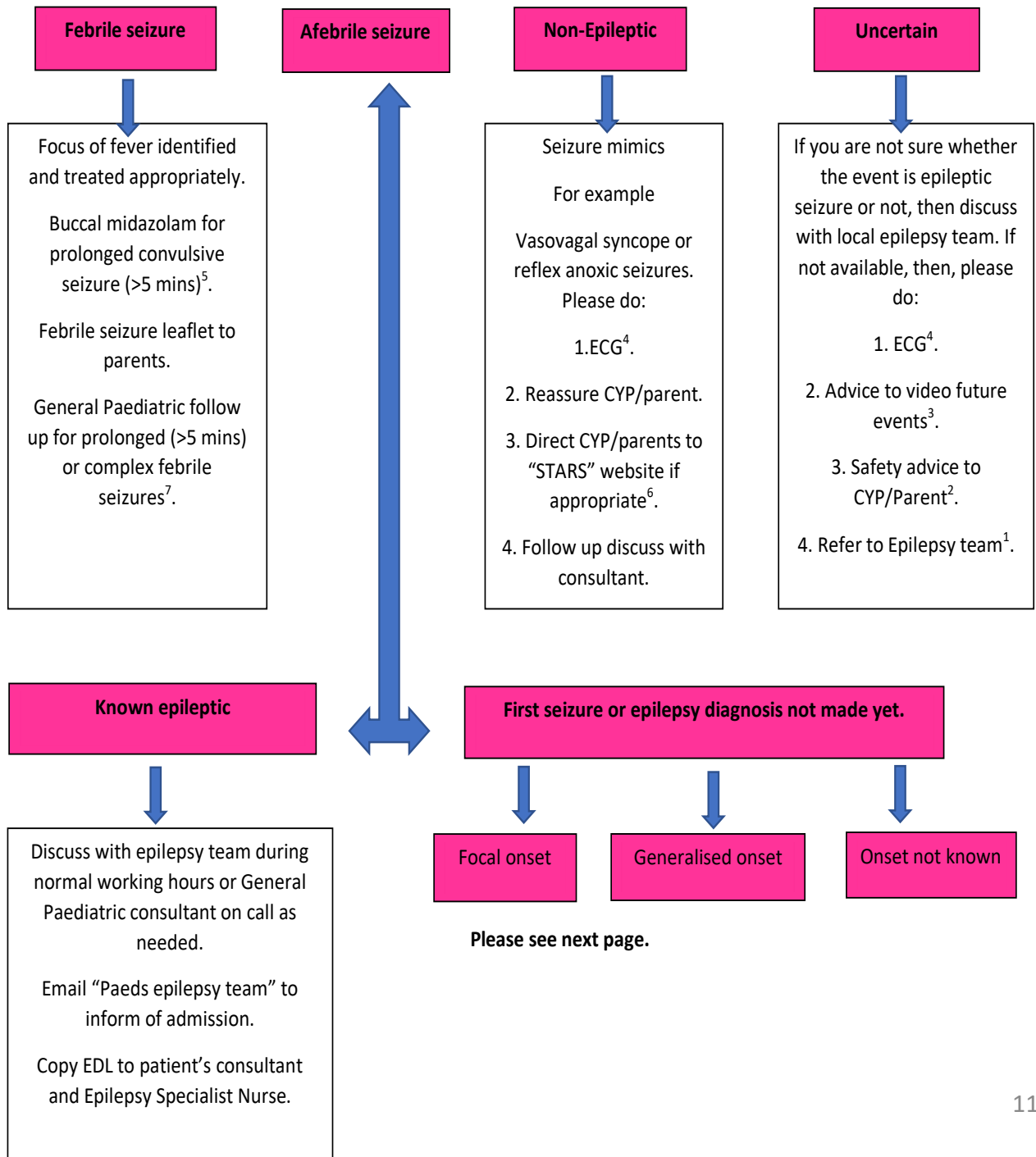
Time:

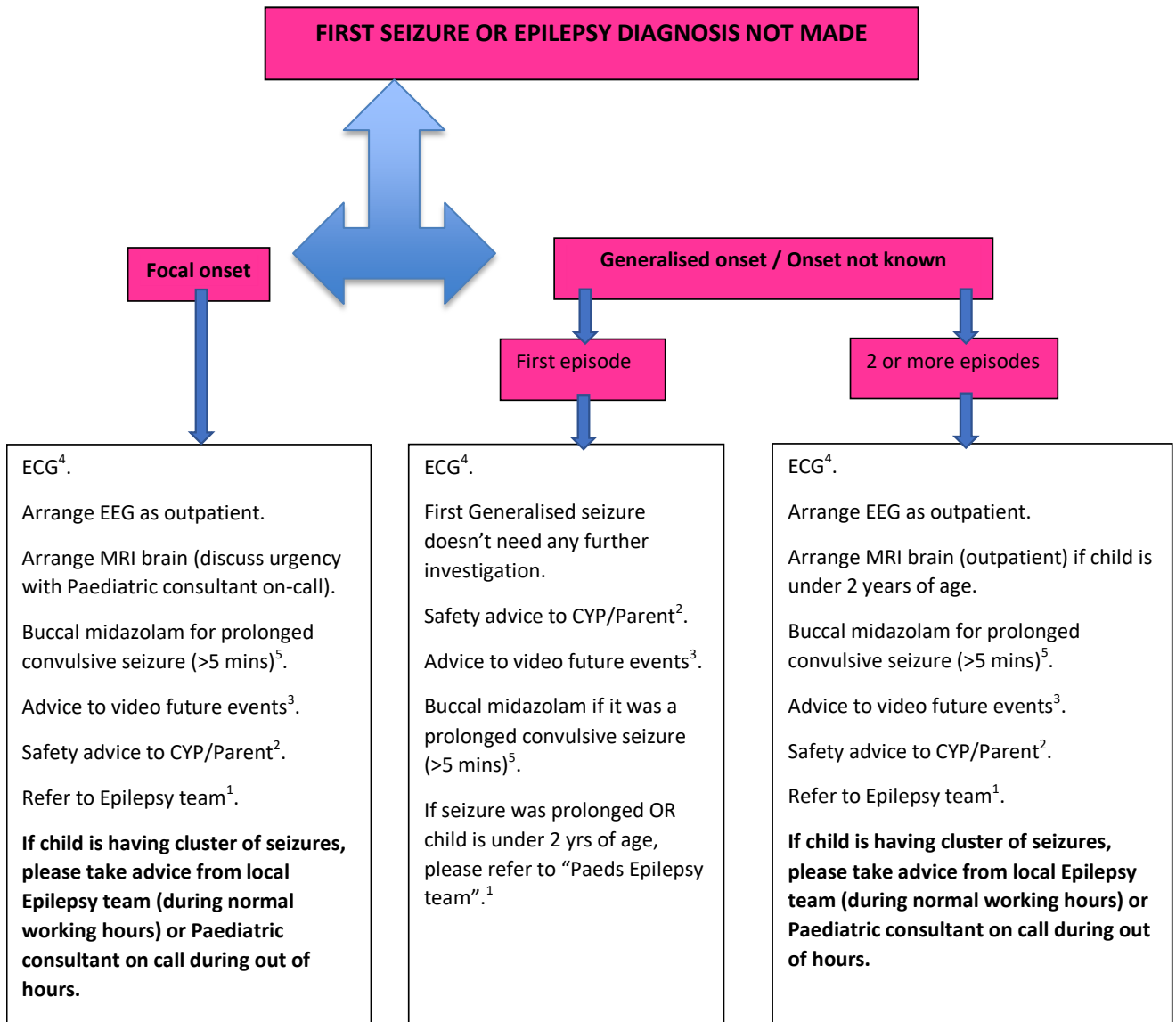
Signature:

Date:

**This guidance does NOT cover acute symptomatic seizures** (like caused by intracranial bleed, meningitis, encephalitis, electrolyte imbalance or hypoglycaemia). They should be suspected when the child hasn't made rapid full recovery after a seizure as expected. If you have a high index of suspicion for them, then please manage accordingly. If you are NOT suspecting acute symptomatic seizure, then please follow the

## Acute admission with Seizure Management





Notes:

1. (Email "Paed Epilepsy team". Referral will not be accepted without EDL OR dictated referral letter. Please provide a detailed account of the event in the EDL or referral letter.
2. Please provide First seizure leaflet to parents and discuss the advice in the leaflet verbally with parents.
3. Advice parents to video further events. Please provide video information leaflet to parents.
4. Check for prolonged QTc on ECG (before discharge) for any event associated with loss of consciousness.
5. For patients with prolonged convulsive seizure which lasted longer than 5 minutes, parents should be trained on buccal midazolam administration before discharge and should go home with midazolam and emergency care plan. Copy of emergency care plan should be sent to Epilepsy specialist nurse.
6. <https://www.heartrhythmalliance.org/> commonly known as "STARS" website provides useful information about common seizure mimics like Vasovagal syncope or Reflex anoxic seizures.
7. Complex febrile seizures are – Longer than 10 -15 mins and/or focal and/or repeated febrile seizures in the same febrile illness.

## Seizure Recording Chart

Date/ time	Duration	What did you see? What body parts are affected?	Obs	Management	Recovery	Witnessed by

## Seizure Discharge Checklist

Do not discharge until form complete

Nursing checklist	Yes	No	N/A	Discharging Nurse	Comments
Have two sets of neurological observations been within normal limits for the child? <b>Final observation must be completed within 1 hour prior to discharge.</b>					
Has SPR/ consultant reviewed child within 1 hour of discharge?					
If required- have family received Buccal Midazolam training & applicable paper work completed (pink folder)?					
TTA's given and explained- NB- Child should be discharged with 2 x Buccolam syringes					
Has BLS been recommended & completed prior to discharge or has this been arranged in community setting (please indicate)					
Are staff happy that parents have fully understood information given- - <b>consider Language Line</b>					

Nursing staff name..... Date.....

Sign.....

Time.....

## Seizure Discharge Checklist

Do not discharge until form complete

Parent Checklist	Yes	No	N/A	Discharging Nurse	Comments
Has your child returned to his/her usual self?					
Do you have any questions or concerns?					
Has rescue medication / TTA been explained to you? Did you understand?					
Have you been given information for : •Seizures •New diagnosis of epilepsy •Febrile seizure advice sheet •BLS •Safety advice					
Have you understood this information?					
Do you know what to do if you child has another seizure?					
Have you been given contact details for local epilepsy team (community & hospital)					

Reviewed by..... Date.....

Sign.....

Time.....

## Notes:

### Discharge observations

Time:..... Date:...../...../.....

Temperature	°C	CRT	
Heart rate	/min	O2 Saturation	
Respiratory rate	/ min	PEWS	
Neuro observation (must be within 1 hour of discharge)	Time:	GCS	

**Has the child returned to their baseline neurological state prior to the seizure?**

**YES / NO**

**If No, discuss with consultant.**

**Same sex accommodation discussed with patient /carer/parent Yes / No**

**Admitted to ward:**

24 25 26 HDU

Patient under follow up by: Dr...../ NA (consultant)

**Handed over to:**

Name of nurse:.....

Name of Doctor:.....

Parents information pack given: Yes / No /NA

**Handed over by:**

Signature:

Print name:.....

Time:..... Date:...../...../.....

**Discharge destination:** Home other:.....

Parking permit given: Yes / No/ NA

Medication: None / Dispensed/  
hosp. prescript/ FP10

Venous access removed: Yes/ No/ NA

Discharge letter given: Yes / No

Information sheet given (specify).....

Follow up:...../Rapid response team: Y/N

Signature:

Print name:.....

Time:..... Date:...../...../.....

### Transfer out

Hospital:

Ward:

Team:

Contact:

		Transferring Nurse	Accepting Nurse
CPIS checked & stamped	YES/NO/NA		
Safeguarding tab checked	YES/NO/NA		
Cannula care plan completed	YES/NO/NA		
Investigations requested?	YES/NO/NA		
Follow up arranged?	YES/NO/NA		
ICE referral made to epilepsy MDT?	YES/NO/NA		